Form 25
June 2007

_____ New _____ Recertification

STATE OF ALABAMA
PERSONNEL DEPARTMENT
REQUEST FOR DONATED LEAVE

Employee Name		SSAN	
Department		Division	
Class Code		Pay Range	

Additional Information:

I do hereby request donated leave under Code of Alabama §36-26-35.2 (2001). This request is due to the catastrophic illness/injury referenced on the attached doctor's statement and is needed in order to continue my compensation because my leave will have been exhausted prior to my return to work. Under the FMLA, if a qualifying illness exists, an employee's job is protected for 12 weeks. I understand that the receipt and/or use of donated leave does not protect an employee's job after the 12 weeks covered by the FMLA are exhausted.

Beneficiary Employee: _____ Date: _____

AUTHORIZATION

I do hereby authorize the State Personnel Department to publish on its web site and in any of its other publications a general description of the illness/injury for which I have been granted donated leave. This authorization is for the purpose of notifying the state workforce of my request for donated leave and soliciting leave on my behalf.

Beneficiary Employee: _____ Date: _____

Pursuant to the Code of Alabama §36-26-35.2 (2001), I request that our employee be approved for receipt of donated leave. A doctor's statement outlining the condition and treatment is attached. I authorize my agency to add the total hours donated after approval by State Personnel to the above beneficiary.

Beneficiary Appointing Authority: _____ Date: _____

Approved

Personnel Director: _____ Date: _____

Donated Leave Approved For: